Expert Witness,
and Injury Evaluation

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Tax ID #: 22-2680537

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May 16, 2017
Re: Talaat M. Mohammed
D/A: 6/17/10
D/E: 4/11/17
Resp: Kearny Steel Container Co.
File #: 2010-16543

Bagolie, Friedman Esqs.
648 Newark Avenue
Jersey City, NJ 07306

Dear Mr. Bagolie:

Please be advised that I did previously evaluate the petitioner on 6/19/12 and most recently on 8/20/13 at which time I had recommended additional treatment. As per your request, this is an updated exam to address permanency. I am aware that this re-exam involves the continuing reopener of a compensation claim which was settled on 11/26/12 with an award of 50% of partial total apportioned at 35% for the right leg, 25% for the right foot, 5% for the left leg and 5% for the left foot. Since the time of the compensation award, the patient's complaints have worsened.

HISTORY:

The patient relates that on 6/17/10 while in the course of his employment with Kearny Steel Container Co., as a mechanic, he sustained injuries to his back, right hip, right knee, left knee, right ankle and left ankle when he was run over by a truck. Following the accident, the patient relates that he was taken to the University Hospital emergency room where he was evaluated, had x-rays taken and was admitted for surgery to his right leg. The patient relates that he underwent inpatient rehabilitation at Kessler Institute for Rehabilitation. The patient relates that he was treated at Care Station and by a Dr. Oppenheim. The patient relates that he was treated at Saint Barnabas Medical Center emergency room and underwent CT scans of the lumbar spine and right knee. The patient relates that he was treated by a Dr. Pflum from Hudson Health Services Associates and underwent MRIs of his lumbar spine, both ankles and an EMG study. He indicates that surgery was also performed on his right ankle and that surgeries for his left knee and left ankle were planned. The patient states that he underwent a course of physical therapy. He states that he did not return to his job after the accident. The patient states that since the time of the compensation award, his condition has continued to deteriorate with increased pain and restriction. He states that he was treated by Dr. Elamir. He relates that he has undergone updated MRI studies of the right and left ankles. He relates that he also underwent updated MRI study of the lumbar spine. He relates that he was seen by a Dr. Oppenheim, who referred him to a Dr. Brady for pain management evaluation. He states that he was seen at Christ Hospital emergency room in 4/15 due to back pain. He states that he underwent an additional MRI study of the lumbar spine. The

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patient relates that he came under the care of a Dr. Sheikh. He states that he was referred to a Dr. Giordano, who performed surgery to his lumbar spine. The patient is presently not employed.

PAST MEDICAL HISTORY:

Hypertension.
Diabetes mellitus.
Depression.
GERD.
Cardiac disease.
12/12/16 - cervical spine surgery

RECORDS REVIEWED:

I did review the medical records and had the benefit of the emergency room records from University Hospital dated 6/17/10 and note an admitting diagnosis of right femur fracture. I also had the benefit of the attending admission note dated 6/17/10 and note an impression of status post crush injury by tractor-trailer, crush injury right midshaft femur fracture. I also had the benefit of the x-ray reports of the right hip, right femur and right and left knees dated 6/17/10 and note an impression of transverse fracture through the mid-distal femur with one shaft width displacement posterior of the distal fragment relative to the proximal, mild lateral displacement of the distal fragment relative to the proximal. I also had the benefit of the CT scan of the cervical spine dated 6/17/10 and note an impression of no fracture or subluxation of the cervical spine, degenerative changes. I also had the benefit of the CT scan of the head dated 6/17/10 and note an impression of no acute intracranial pathology. I also had the benefit of the CT scan of the chest, abdomen and pelvis dated 6/17/10 and note an impression of no evidence of traumatic injury. I also had the benefit of the x-ray report of the left knee dated 6/17/10 and note an impression of no acute fracture or dislocation. I also had the benefit of the x-ray report of the pelvis and right femur dated 6/17/10 and note an impression of no pelvic fracture identified, both femoral heads appear located with respect to the acetabula, pubic symphysis is preserved, fracture of the junction middle and distal third of the right femoral shaft with approximately 8 mm lateral displacement of the distal fracture fragment. I also had the benefit of the x-ray report of the chest dated 6/17/10 and note a normal study. I also had the benefit of the operative report from University Hospital dated 6/17/10 and note the preoperative diagnosis of right distal femur fracture. I note that open reduction internal fixation of the distal femur with Smith and Nephew nail 10 x 38, distal lock is 45 and 65, proximal is 65 mm performed by a Dr. Lin. I also had the benefit of the MRI of the right knee dated 6/19/10 and note an impression of full-thickness medial collateral ligament tear and what appears to be injury to the medial patellofemoral ligament, injury to the medial retinaculum noted, bone marrow edema in the proximal tibia which may be secondary to contusion or occult fracture, soft tissue density interposed between the superior surface of the medial meniscus and medial femoral condyle, lower grade injuries to the anterior and posterior cruciate ligaments, the biceps femoris tendon. I also had the benefit of the x-ray report of the right femur dated 6/17/10 and note an impression of status post IM nailing and screw fixation of the midshaft femur fracture, anatomic alignment improved, minimal posterior angulation of the fracture apex. I also had the benefit of the discharge summary from University Hospital dated 6/22/10 and note that the patient was status post intramedullary nail fixation of the right femur and was diagnosed with a medial collateral ligament injury of the ipsilateral knee. I also had the benefit of the admission notes from Kessler Institute for Rehabilitation dated 6/22/10 and note that the patient presented with complaints of gait and ADL dysfunction secondary to lower extremity trauma. I also note that the patient underwent an ORIF on 6/17/10 for a right mid shaft femur fracture. I also had the benefit of the discharge notes from Kessler Institute for Rehabilitation for a stay from 6/22/10 through 8/13/10 and note an impression of status post right ankle ORIF, status post right

femoral ORIF, hypertension, hypercholesterolemia, non insulin dependent diabetes and GERD. I also had the benefit of the treatment notes from Care Station dated 12/2/10 through 1/19/11 and note an impression of DVT right lower leg with coumadin therapy. I also had the benefit of the treatment notes by Dr. Oppenheim dated 12/21/10 and note that the patient presented with complaints of right hip, right knee and right ankle pain. I also note that x-rays were taken of the right femur and hip and note an impression of the locked rod is in place, the proximal oblique locking screw was noted, the fracture distally within the femur did demonstrate ongoing healing with the alignment being maintained, there was significant healing appreciated and no evidence of any loosening of the distal screws. I also note that x-rays were taken of the right knee and note an impression of the medial and lateral joint lines are maintained, there was evidence of a medial capsular sign and the patella femoral joint was maintained. I also had the benefit of the operative report from Saint Barnabas Medical Center dated 1/26/11 and note a preoperative diagnosis of status post open reduction internal fixation of right femoral shaft fracture with locked femoral nail, right trochanteric bursitis, painful hardware of right greater trochanteric region, heterotopic bone wide insertion site. I note the patient had undergone a release of iliotibial band, greater trochanteric bursectomy, partial removal of hardware and excision of heterotopic bone performed by a Dr. Oppenheim. I also had the benefit of the discharge summary from Saint Barnabas Medical Center dated 1/29/11. I also had the benefit of the treatment notes by Dr. Oppenheim dated 2/10/11 and note an impression of status post removal of the proximal locking screw of his femoral rod, right trochanteric bursectomy and release of the iliotibial band and incision of a heterotopic bone on 1/26/11. I also note that x-rays were taken of the right femur and hip and note an impression of absence of the proximal locking screw. I also had the benefit of the treatment notes from Care Station dated 2/23/11 through 3/16/11. I also had the benefit of the treatment notes by Dr. Oppenheim dated 3/10/11 through 5/5/11 and note that the patient was referred for a course of physical therapy. I also had the benefit of the CT scan of the lumbar spine from Dynamic Medical Imaging dated 7/2/11 and note an impression of L5-S1 massive broad based disc herniation, bilateral intraforaminal stenosis, severe bilateral foraminal narrowing and mild to moderate canal stenosis with hypertrophic facet disease, L4-L5 massive broad based disc herniation with osteophytic components, moderate to severe bilateral foraminal narrowing, severe central canal stenosis, hypertrophic facet disease, ligamentum flavum, L3-L4 broad based disc bulge, central disc herniation indents the ventral thecal sac with moderate central canal stenosis and mild to moderate bilateral foraminal narrowing, L2-L3 broad based disc bulge and foramina mildly narrowed and L1-L2 central disc herniation indenting the ventral thecal sac. I also had the benefit of the CT scan of the right knee from Dynamic Medical Imaging dated 7/2/11 and note an impression of there is an intramedullary rod in the distal femur which extends to the level of the proximal metaphysis and this is transfixed by perpendicular screws across the distal diaphysis, partial ossification of medial collateral ligament at its femoral epicondylar insertion is consistent with previous severe injury and myositis ossificans of the medial collateral ligament and moderate severe narrowing of the lateral patellofemoral joint likely grade 3 and 4 chondromalacia patella and some superimposed osteoarthritis. I also had the benefit of the report by Dr. Holden dated 7/11/11 and note that the patient is seen for lower extremity and back pain. I also had the benefit of the electrodiagnostic report from Dr. Vora dated 8/24/11 and note complaints of lower back pain. I note impression of evidence of right L4 and left L5/S1 radiculopathy. I also had the benefit of the MRI report of the left ankle dated 12/14/11 and note an impression of 10 X 6 mm osteochondral lesion in the medial talar dome with diffuse surrounding edema, effusion of the dorsal talocalcaneal joint, otherwise unremarkable study. I also had the benefit of the MRI report of the left knee dated 12/15/11 and note an impression of medial meniscal tear, fraying of the lateral meniscus and patellofemoral osteoarthritis. I also had the benefit of the treatment notes by Dr. Pflum from Hudson Health Services Associates dated 12/20/11 through 3/1/12 and note that the patient was

referred for surgery to the left knee. I also had the benefit of the treatment notes by Dr. Pflum dated 3/6/12 and note that the patient was referred for MRIs of the right knee and lumbar spine. I also had the benefit of the MRI report of the lumbosacral spine dated 3/9/12 and note impression of diffuse bulging of the T11-T12, L1-L2, L3-L4, L4-L5 and L5-S1 discs, scoliosis convexity towards the right, incidentally noted is a large cystic structure of the left kidney, correlation with ultrasound or CAT scan may be advised. I also had the benefit of the MRI report of the right knee dated 3/9/12 and note impression of moderately limited exam, mild soft tissue swelling about the right knee, small right knee joint effusion, there are no fractures or dislocations, intermedullary nail and sliding screws within the visualized distal femur which is resulting adjacent susceptibility artifact, evidence for an old tear involving the anterior fibers of the medial collateral ligament with an area of calcification in this region, mild soft tissue edema seen in the expected location of the proximal posterior fibers of the MCL suggestive of a tear in this region; there is no gross meniscal tear, of note, evaluation of the menisci is limited by motion artifact; moderate focal degenerative change along the central aspect of the lateral femoral trochlea, moderate to marked articular cartilage fissuring at the junction of the patellar apex and lateral patellar facet. I also had the benefit of the treatment notes by Dr. Pflum dated 3/22/12 and note that the patient underwent an MRI of the left knee in the past which was positive for a tear of the medial meniscus. I also note that the patient underwent MRIs of both ankles and note an impression of left ankle osteochondral defect of the medial talar dome that is of significant size. I also note that the patient underwent an EMG study in the past and note an impression of right L4 and left L5-S1 radiculopathy. I also note that the patient was referred to a pain management specialist for possible epidural steroid injections. I also had the benefit of the report of Dr. Oppenheim dated 3/29/12. I also had the benefit of the emergency room report from Jersey City Medical Center dated 4/11/12 and note that the patient is seen with complaint of chronic back and leg pain for 1.5 years. I note diagnosis of low back pain. I also had the benefit of the x-ray report of the lumbar spine dated 4/11/12 and not impression of osteoarthritic changes. I also had the benefit of the x-ray report of the right knee dated 4/11/12 and note impression of no fracture. I also had the benefit of the x-ray report of the right ankle dated 4/11/12 and note impression of no fracture. I also had the benefit of the treatment notes by Dr. Oppenheim dated 6/13/12 and note that the patient continued complaints of back pain and lower extremity pain. I also had the benefit of the report of Dr. Elamir dated 7/16/13 and note the patient was under care including chiropractic adjustments and physical modalities. I also had the benefit of the report by Dr. Thrower dated 1/21/14 and note that the patient has previously been seen on 8/21/12 and has not had any additional treatment. I note continued complaints of pain around the right hip, right knee, right ankle, left knee and left ankle. I also note complaints of stiffness and pain in the left elbow. I note continued impression of fracture of the right femur, fracture of the right medial malleolus of the ankle, sprain of the medial collateral ligament of the right knee, sprain of the left knee and ankle. I also note impression that, with regards to the lumbar spine, he had a lumbar sprain with lumbar disc abnormalities likely pre-existing and typical of aging. I also had the benefit of the report from Dr. Carnevale dated 2/18/14 and note that the patient is seen for psychological treatment secondary to persistent pain complaints and complaints of psychological adjustment issues. I note that treatment is suspended to lack of progress. I also had the benefit of the x-ray report of the left ankle dated 2/19/14 and note impression of no acute osseous soft tissue abnormality identified. I also had the benefit of the x-ray report of the left ankle dated 2/25/14 and note impression of 1.3 cm focal area of signal abnormality seen within the medial talar dome at the articular surface with overlying cartilage thinning suggestive for an osteochondral lesion versus prominent subchondral cyst/intraosseous ganglion, high-grade sprain versus partial tearing of the posterior tibiofibular and talofibular ligament, prominent degenerative changes at the articulation of the navicular bone with the medial and lateral cuneiform bones, adjacent lobulated fluid intensity signal foci at that level at the dorsal aspect which may represent prominent traversing vessels

and/or ganglion. I also had the benefit of the MRI report of the right ankle dated 3/18/14 and note impression of 6 mm osteochondral lesion of the medial talar dome at the articular surface with prominent surrounding reactive edema, note disassociation of the fragment. I also had the benefit of the MRI report of the right foot dated 3/18/14 and note impression of low grade sprain of the Lisfranc ligament, mild degenerative changes at the first metatarsal bone. I also had the benefit of the report from Dr. Skolnick dated 4/7/14 and note the patient continues to complain of his back, right hip, both knees and ankles with weakness. I note that there is occasional clicking and giving way in the knees with swelling with overuse, there is significant lumbar spine pain and both ankles give him problems as well with swelling at the end of the day. I note diagnosis of chronic lumbar strain, lumbar radiculopathy, lumbar herniated discs L3-4, L4-5 and L5-S1, aggravation of pre-existing lumbar degenerative disc disease, right mid shaft femur fracture, status post open reduction internal fixation right femur, status post removal right proximal locking screw femoral rod, right trochanteric bursectomy and release of iliotibial band, painful femoral hardware with heterotopic bone formation, right knee chondromalacia patella, left torn medial meniscus and fraying lateral meniscus, post-traumatic full-thickness medial collateral ligament tear right knee, tear medial postellofemoral ligament, posterior cruciate biceps femoris tendon right knee, DVT right lower extremity. I note opinion that the patient should undergo operative arthroscopy of the left ankle to address the problem in the medial talar dome with a course of postop physical therapy. I also had the benefit of the report by Dr. Thrower dated 7/8/14 and note that the patient complains of continued pain in both ankles, right hip, both knees, lower back and the left elbow. I note that impression remains the same. I also had the benefit of the psychiatric need for treatment report by Dr. Wong dated 10/27/14 and note conclusion of post-traumatic stress disorder plus adjustment disorder with depressed mood secondary to pain and functional issues related to physical injuries with recommendation for psychotropic, medication and cognitive behavorial therapy. I also had the benefit of the psychological evaluation report by Dr. Carnevale dated 11/28/14 with diagnostic impression of adjustment disorder with mixed emotional features with recommendation for outpatient visits. I also had the benefit of the MRI report of the lumbar spine dated 11/19/14 and note disc bulge/protrusion at L5-S1, disc bulge at L4-L5, disc bulge/protrusion at L3-L4. I note impression of scoliosis of lumbar spine, multilevel DJDs, L3-L4 through L5-S1 spinal stenosis, neural foraminal stenosis, bilateral L4, L3 and L5 root compression, left largest renal cyst. I also had the benefit of the report by Dr. Oppenheim dated 12/5/14 and note that the patient was previously seen on 10/11/13. I note impression that additional treatment to any of the regions that he presently complains about, including left elbow, lumbar spine, right hip, both knees, right and left calves and both ankles, would not provide him with any significant benefit. I note referral for evaluation by Dr. Brady purely for pain management however not for consideration of interventional injections. I also had the benefit of the report by Dr. Brady dated 12/20/14 and note that the patient is seen with complaints of pain in his right ankle with waking, pain in the right knee with ascending stairs, circumferential pain about the left elbow, low back pain with flexion or lifting. I note assessment of disc protrusions L3-4, L4-5 and L5-S1, status post right hip, right knee and right ankle surgery. I note opinion that it is questionable at this point in time if therapy would make an difference, he is not a candidate for chronic medical management, he may use nonsteroidal anti-inflammatories on a p.r.n. basis; consideration should be made for functional capacity evaluation. I also had the benefit of the emergency room report from Christ Hospital dated 4/8/15 and note that the patient was seen with low back pain. I also had the benefit of the MRI report of the lumbar spine dated 4/20/15 and note impression of multilevel disc bulges at L1-L2, L2-L3, L3-L4 and L4-L5, disc bulge with left central protrusion, moderate spinal canal stenosis at L3-L4 and L4-L5, severe bilateral neural foraminal stenosis at L5-S1. I also had the benefit of the report of the CT scan of the abdomen/pelvis dated 4/20/15 and note impression of septated left renal cyst measuring 4.5 cm, this appears mildly enlarged compared to prior CT, consider CT for further

evaluation, right kidney 2 cm simple cyst. I also had the benefit of the reports by Dr. Sheikh dated 5/20/15 and 6/10/15 and note that the patient presents with complaint of back pain radiating down to right and left leg. I note that he has tried 6 months of conservative management with physical therapy and NSAIDs with limited relief. I note that MRI of the lumbar spine had findings of HNP at L1/2 through L5/S1, ligament hypertrophy L3/4, L4/5. I note that he will try one injection for pain relief. I also had the benefit of the report by Dr. Tikoo dated 7/27/15 and note that the patient is seen for neurological evaluation. I note complaints of post traumatic headaches, neck and back pain. I note that he has headaches, dizziness, shaking in the legs. I note that he is always dropping things and has tremors. I note that MRI study of the cervical spine dated 6/5/15 reveals findings of multilevel degenerative changes. I note that MRI study of the brain dated 6/5/15 reveal findings of no acute pathology, mild age appropriate trophy, mild small vessel disease, basal ganglion chronic lacunes, severe foraminal stenosis on the right at C4-5, C5-6 and C6-7. I note that EMG/NCV study of the lower extremities revealed left sural and right tibial neuropathy, no radiculopathy. I note that EEG study dated 6/10/15 was unremarkable. I note that EMG/NCV of the upper extremities reveals bilateral median neuropathy, no radiculopathy. I note assessment of headaches with unclear etiology; radiating back pain; radiating neck pain. I note outside PT is pending. I also had the benefit of the psychiatric evaluation report by Dr. D'Amato dated 7/7/15 and note diagnosis of major depressive disorder, post-traumatic stress disorder, generalized anxiety disorder, pain disorder. I also had the benefit of the reports by Dr. Giordano dated 11/20/15 and 1/25/16 and note that the patient has undergone 4 operations in the right leg and describes no significant treatment or intervention with regards to his neck or back. I note that he describes having back pain and sciatic type pain down the right leg as well as some neck pain and a feeling of dizziness that has never really been addressed. I note that he was advised that he does have stenosis and herniations that will need to be addressed and that those findings account for his sciatic type pain down the right leg. I note that he has had some injections recommended but he was advised that they would not be curative. I note that he has been out of work since 2010. I note that MRI of the lower back reveals spinal stenosis at L3-4,5 and S1 and the stenosis appears to be secondary to degenerative disc disease and facet hypertrophy. I note that he has a cervical MRI that reveals degenerative disc disease and disc protrusions at C4-5, C5-6 and C6-7. I note impression of L3 through S1 degenerative disc disease and stenosis most likely preexisting and aggravated by his accident, degenerative disc disease and stenosis in the cervical spine aggravated by his work injury, the diagnosis does appear causally related to the work injury described by the patient. I note recommendation that, at this stage, he does not require intervention of the neck especially since he does not have radicular complaints; he does have back pain radiating down the right leg and radiographic findings that correlate with that and at this stage it would be reasonable to proceed with a decompression at L3 to the sacrum to alleviate his sciatic symptoms. I also had the benefit of the neuropsychiatric evaluation report of Dr. Gallina dated 1/31/16 and note physical symptoms that include pain in his back, hip, both knees, ankle and elbows. I note diagnosis of chronic pain syndrome. I also had the benefit of the reports by Dr. Giordano dated 3/11/16 and 3/31/16 and note that the patient was scheduled for back surgery but it was cancelled as he was on a blood thinner. I also had the benefit of the operative report from Morristown Medical Center dated 4/11/16 and note preoperative diagnosis of spinal stenosis at L3, L4, L5, S1. I note that laminectomy of L3, L4, L5, S1 to decompress the L3, L4, L5, S1 nerve roots for a 4 level laminectomy along with a lateral recess decompression and foraminotomy, with partial facetectomy at each level; L3, L4, L5, S1 microdissection of the nerve roots using the operating microscope; interpretation of intraoperative x-rays without the presence of a radiologist was performed by Dr. Giordano. I also had the benefit of the reports by Dr. Giordano dated from 4/26/16 through 6/8/16 and note that the patient is status post lumbar laminectomy. I note that he is using a cane for balance and is happy with his improvement with about 60 to 70% improvement

to his pre-operative state. I note that he still describes some bilateral knee pain, bilateral ankle pain and left elbow pain that he has had for years. I note that he is deferred to an orthopedist. I note that the patient would like to address his neck. I note his main complaint is neck pain that radiates down the left arm but he also gets dysesthesias down the right arm. I note that he also gets headaches. I note diagnosis of C4 through C7 degenerative disc disease and stenosis aggravated by his work injury. I note that the patient wishes to proceed with an anterior cervical decompression and fusion from C4 through C7. I also had the benefit of the electrodiagnostic report of the upper extremities from Dr. Tikoo dated 6/16/16 and note neck pain associated with headaches.

COMPLAINTS:

The patient complains of constant, daily low back pain that is often stabbing in nature. He also has fairly constant right hip pain and stiffness. He continues to experience intermittent clicking of his right hip. He relates that his back and right hip are always stiff and all movements from his waist are extremely restricted. He cannot bend forward to pick up objects on the floor or to put on his shoes. He states that he cannot lift, carry, push or pull any substantial weight. He relates that he cannot sit or stand in one position. He relates that he must frequently change positions or get up and walk around; often requiring assistance. He also complains of persistent radiating pain and numbness in his lower extremities. He also complains of increasing pain to his knees and ankles. He relates that his legs feel weak and "shaky". He states that his mobility is very restricted and he must use a cane for assistance. He complains of swelling in his knees and ankles with any prolonged activities. He is aware of persistent popping and grinding sensation in his knees and ankles. He has experienced episodes of giving out of his knees. He cannot fully bend or extend his legs. He cannot kneel or squat and has difficulty going up and down stairs. He relates that he has difficulty with daily chores and cannot join friends and family for many social activities. He relates that his scars remain tender and sensitive. He states that by the end of the day he must elevate his legs to try to alleviate the swelling. He states that he has difficulty sleeping comfortably and frequently awakens due to back spasms. He complains of increased pain when he gets up in the morning. He states he still experiences increased pain when the weather changes.

PHYSICAL FINDINGS:

The patient is a 5'6", 175 lbs., right handed, 63 year old male.

Please be advised that both active and passive range of motion were carried out; active range of motion is subjective and passive range of motion is objective. These measurements were recorded with objective medical device known as goniometer and a coefficient of validity was performed with respect to the passive range of motion. To document my objective findings, credibility testing was also performed.

Physical examination reveals that the patient walks with a cane.

The following findings relate to the lumbodorsal, lumbar and bilateral lower extremity areas. Inspection reveals a 6" laminectomy scar present which is hyperpigmented. There is fixation and partial adherence to the underlying tissue. There is pain and tenderness elicited upon palpation. Inspection reveals increased, marked curve flattening which involves the lumbodorsal and lumbar curves and extends to the sacrum. There is an increased marked loss of the lumbar lordosis appreciated. There is persistent tenderness and hardness noted over the lumbar paraspinals, iliolumbars and sacroiliacs. Trunk flexion lacks 55 degrees, extension lacks 40 degrees, bending bilaterally lacks 40 degrees and twisting bilaterally lacks 35 degrees. There is noted to be

increased rigidity through the lower lumbar segment on all trunk motion. On the extremes of trunk motion, there are increased complaints of more marked pulling and pain through the lumbar paraspinals, iliolumbars, sacroiliacs, gluteal and posterior thigh areas. There is increased bilateral hamstring spasm with sciatic notch tenderness. The straight leg raising test on the right is carried out to 55 degrees on the left to 40 degrees. Patrick's and Lasegue's test are positive.

The following findings relate to the right hip. Inspection reveals a 7" zone of scarification present. There is increased pain noted with palpation. Palpation was carried out about the anterior superior iliac spines as well the iliac crest. The posterior superior iliac spines and greater trochanter were also palpated. Hip flexion lacks 40 degrees, extension lacks 25 degrees, abduction lacks 40 degrees, adduction lacks 30 degrees, internal rotation lacks 25 degrees and external rotation lacks 25 degrees.

The following findings relate to the right leg and knee. Inspection reveals a 3" zone of scarification present about the popliteal fossa. There is continued pain noted with palpation. There is also persistent and diffuse swelling appreciated. In the anterior compartment, there is increased tenderness noted with palpation about the infrapatellar tendon. There is also increased tenderness noted with palpation about the superior and inferior pole of the patella and over the medial and lateral facets of the patella. In the medial compartment, there is persistent tenderness noted over the meniscus, the medial femoral condyle and the medial collateral ligament. In the lateral compartment, there is persistent tenderness noted over the lateral femoral condyle and the lateral collateral ligament. In the posterior compartment, there is persistent tenderness elicited upon palpation about the lateral and medial hamstrings. The anterior drawer test is positive. The posterior drawer test is positive. McMurray's test is positive. Flexion is to 70 degrees, extension is to 0 degrees. Medial rotation of the tibia on the femur is to 10 degrees, and lateral rotation of the tibia on the femur is to 10 degrees.

The following findings relate to the left knee region. There is continued pain noted with palpation. There is also persistent and diffuse swelling appreciated. In the anterior compartment, there is increased tenderness noted with palpation about the infrapatellar tendon. There is also increased tenderness noted with palpation about the superior and inferior pole of the patella and over the medial and lateral facets of the patella. In the medial compartment, there is persistent tenderness noted over the meniscus, the medial femoral condyle and the medial collateral ligament. In the lateral compartment, there is persistent tenderness noted over the lateral femoral condyle and the lateral collateral ligament. In the posterior compartment, there is persistent tenderness elicited upon palpation about the lateral and medial hamstrings. The anterior drawer test is negative. The posterior drawer test is negative. McMurray's test is positive. Flexion is to 85 degrees, extension is to 3 degrees. Medial rotation of the tibia on the femur is to 25 degrees, and lateral rotation of the tibia on the femur is to 20 degrees.

The following findings relate to the right ankle and foot. There is persistent swelling and flattening noted over the lateral and medial regions. Inspection reveals a 3" zone of scarification present about the medial aspect of the foot. There is continued pain noted with palpation. Plantar flexion is to 15 degrees, and dorsiflexion is to 5 degrees. Supination is to 10 degrees, and pronation to 10 degrees. Forefoot adduction is to 3 degrees, and forefoot abduction is to 3 degrees. Inversion is to 2 degrees and eversion is to 2 degrees. The following joint play movements were carried out. At the talocrural joint, long axis extension and anteroposterior glide were carried out. At the subtalar joint, talar rock and side tile medially and laterally were carried out. At the midtarsal joints, anteroposterior glide and rotation were carried out. At the tarsometatarsal joints, anteroposterior

CONCLUSION:

In conclusion there is a causal relationship between the aforementioned diagnosis and the accident of 6/19/12. The objective medical findings noted have resulted in a permanent impairment of 85% of the right leg, a permanent impairment of 40% of the left leg, a permanent impairment of 55% of the right foot, a permanent impairment of 40% of the left foot and an orthopedic disability of 75% of partial total.

Very truly yours,

M. Horwitz M.D.

Morris Horwitz, M.D.

Amount due for examination and report $600.00

This report has been prepared exclusively for the purpose of a Worker's Compensation proceeding. Any other use of this report and its contents is unauthorized without the express consent of this office.

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